Report of the RBM Partnership/Global Fund for AIDS, Tuberculosis and Malaria Meeting of West and Central African Countries:

Identifying and Overcoming Malaria Programme Implementation Bottlenecks

27-29 March, 2006, Le Meridien President Hotel, Dakar, Senegal

Introduction to the Regional Meeting

1. The joint regional meeting held by the Roll Back Malaria (RBM) Partnership and the West and Central Africa Cluster of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) on *Identifying and Overcoming Malaria Programme Implementation Bottlenecks* took place in Dakar, Senegal from 27-29 March, 2006 at Le Meridien President Hotel. The meeting received financial support from USAID, MSH, GFATM and the RBM Partnership Secretariat. The objectives of the meeting were to identify malaria programs' needs and formulate strategic plans to resolve implementation bottlenecks specific to Global Fund grants; to facilitate countries access to Technical Assistance and discuss scaling up for impact; and; to facilitate the efficient allocation of resources to achieve scaling up for impact.

2. The meeting brought together recipients of GFATM malaria grants from West and Central African countries of Benin, Central African Republic, DRC, Ghana, Guinea (Conakry), Guinea Bissau, Liberia, Niger, Nigeria, Senegal, Sierra Leone and Togo, representing grant Principle Recipients (PRs); National Malaria Control Programme and the Country Coordination Mechanism (CCM)) and RBM Partners from more than 30 different organizations. Overall, more than 90 people attended the meeting.

3. The meeting was designed to facilitate an exchange of information between country programs and RBM partners. The goal of the first day was to exchange experiences and best practices on specific technical issues. Five technical themes were each presented by a country representative and an RBM partner respectively. Following each presentation, participants were divided into working groups to identify key challenges and responses for each theme. The groups then presented their findings in plenary. The goal of day 2 was to introduce country delegations to RBM partners and exchange information on the types of support available to different programmes. In the final session, each country delegation with the assistance of specific RBM partners, worked together to develop a country action plan to address bottlenecks and apply solutions identified in the workshop and consider options for scaling up and available assistance from partners. Each country then presented their action plan in plenary.

All meeting information could be found at:
http://www.theglobalfund.org/en/in_action/events/regionalmeetingafrica/dakar_03_2006/default.asp

Plenary session: Setting the Framework for the Regional Meeting

4. The meeting was opened by short statements from Dr John-Paul Clark (USAID); Dr Malick Diara (MSH RPM +); Mr Mabingue Ngom (GFATM); and Prof. Awa Coll-Seck (RBM Partnership Secretariat). The honorable Abdou Fall, Minister of Health, Senegal, welcomed all participants to Senegal and stressed the importance of winning the battle to roll back malaria. Professor Awa Coll-Seck, the Executive Secretary of the RBM Partnership Secretariat presented an overview of the meeting including the objectives, expected outcomes, agenda, principles, and structure.

5. The introductory plenary session started with a review of the objectives, the agenda and the methodology of the meeting by clarifying expected outcomes from the meeting which were: Preparation of country specific activities to address bottlenecks in implementation of Malaria programs; Identification of support for implementing solutions (sources and mechanisms for provision of technical assistance support); and Sharing of solutions to remove bottlenecks for impact.

6. To set the framework for the three days the West and Central Africa cluster leader Mr Mabingue Ngom presented an update of the Global Fund, which included an overview of malaria grants in the Global Fund, the status of funds disbursed in the West and Central African region. Mr Ngom highlighted that thirty one percent of global GFATM grants go for fighting malaria; GFATM has awarded US$453,109,000 in malaria grants (rounds 1-5) to countries in this region (nearly 29% of all GFATM grants awarded in this region); and that 60% of all GFATM malaria grants in this region demonstrate poor performance and could potentially fail.

Day 1: Monday, 27 March

7. After the initial introduction, Day One was organized into two sessions to discuss five themes. Each theme was introduced by a country and a partner. At the end of each presentation, countries and partners split in working groups to discuss the key findings, problems and solutions. Recommendations from each working groups were presented to the plenary.

Session 1 Achieving greater impact

8. **"Thinking for impact: Managing policy shifts from current treatment to ACTs." Ghana** presented its experience including information on how and when a new drug policy was developed; identification and resolution of implementation bottlenecks; good practices and lessons learnt. To ensure that there were enough ACTs while chloroquine is being phased out the process was planned to occur over three years. Ghana is looking to pre-qualify three local suppliers to produce ACTs. However, utilisation of local manufacture of ACTs is not possible unless they go through the pre-qualification procedure. **RPM+** presented an overview of different steps needed through the entire policy shift including the development of a new policy; transition to the new policy and implementation of the new policy. **Recommendations** from the group discussions highlighted that political commitment of government and partner support before policy change is a must. The transition phase must have a consensus on what drugs will be used. As soon as drug policy change is made funds must be made available and proper planning is needed to ensure an adequate and timely supply of drugs. There is a need to ensure equitable access to drugs by entire population at risk, especially the most vulnerable (e.g. pregnant women, children, poor). Drug suppliers, manufacturers and WHO were requested to speed up pre-qualification to facilitate local production and registration. Strong drug surveillance, training and sensitization to promote acceptance are needed. Government should be recommended to subsidize the new drugs and partners should help to ensure there is sustainable financing

9. **"Managing for impact: Procurement and supply management systems." Distributing to reach the poor" Niger** presented a case study based on its procurement and supply management experiences associated with the delivery of ITNs in conjunction with a polio campaign for the whole country. Niger was able to achieve very high coverage of vulnerable populations (98%) by combining these two activities. However,

the combined campaign took an enormous amount of planning, financial resources and strategic distribution to reach the entire country. **RPM+** presented an overview of the steps needed to develop an effective distribution system including information on the procurement and supply management cycle; opportunities and challenges in procuring antimalarial commodities; equity considerations in distribution; and potential mechanisms for accelerating procurement and distribution of insecticides and ITNs. **Recommendations** from the working group flagged the need for a strong planning process and communication among all players responsible for the implementation of the plan. Ghana's example of distributing ITNs to pregnant women through a voucher system was recommended as a way to involve the private sector to scale up activities. Using a non traditional procurer (e.g. PSI), as a procurement agent can help countries to avoid delays. Partners based in countries must be involved to develop solutions, plan in a timely manner, develop the PSM plans early and not after announcement of GF rounds. NGOs and the private sector may be able to facilitate procurement for PRs instead of referring to international procurers only. Biannual reports on supply and demand would help countries and suppliers to quantify expectations. Anticipate and plan to respond to turf issues and competing interests.

10. **"Measuring impact: Harmonizing reporting requirements and systems." Benin** presented their experience and outlined steps taken to develop a harmonized reporting system. This process involved reaching consensus on what indicators to monitor; identifying partners to assist with monitoring and analysis; establishing baseline conditions; working with other programmes to collect relevant information; developing a comprehensive national strategy; and using data to improve the programme. **PATH-MACEPA** presented information on the importance of developing one national monitoring and evaluation plan which all of the partners buy-into to increase efficiency and reduce duplication. Such a plan should be developed around indicators for following: inputs, processes, outputs, outcomes, and health impact. **Recommendations** from the working group indicated that development of one clear national monitoring and evaluation plan linked to the country strategic plan is the most effective/efficient approach. Agreement should be reached on what indicators are needed (indicators will need to be periodically reviewed and updated as warranted). Quality of data is important and should be emphasized. For that, GFATM funding allocation should be encouraged specifically for M&E. Questions were raised regarding donors providing funds separately for M&E rather than supporting one M&E plan. There is a need for clarity on consistency for impact & outcome indicators and suggested indicators for inputs-process-outputs. External partners can help countries and country-partners by harmonizing their monitoring and evaluation requirements.

Session 2 Managing for Scaling Up

11. **"Towards performing PR organizations. Managing programs that work." Senegal** presentation outlined the process used to develop a functional PR structure including: decentralization, increasing staff and human resource capacity, developing and using appropriate contracting procedures, collaboration between partners and creating trust between the service providers and the beneficiaries. **PWC Ghana** highlighted the need for planning, effective communication, teamwork, pro-activity, political support, collaboration between partners and a strong and vibrant CCM as pre-requisites for an effective PR organization. **Recommendations** from the working groups underlined that management capacity of PR remains an issue, including proper planning, follow-up and feedback. The PR's technical and managerial capacity, depending on country context and grant size, might call for multiple PRs. SR management is an area of concern. PRs must be part of SR selection committees; multiple SRs should be selected based on their unique comparative advantage and contracts with the SR should be developed on

performance based principles. Stakeholder management including CCM relationships and effective communication between the CCM and LFA, SR and FPM are needed.

12. **"Mobilizing local actors for scaling up. Developing capacities and managing national and local organizations to scale up malaria interventions." Central African Republic** presentation focused on problems faced in mobilizing local actors for scaling up. Existing NGOs did not have sufficient capacity to implement activities and as a result, the programme introduced mechanisms to assess the competencies and capacities of different NGOs. They also introduced performance based contracts for them. The **MSH** presentation underlined different types of sub-recipients and outlined problems associated with mobilizing local actors including too many SRs, poor work-plans, lack of communication/coordination, insufficient capacity and absence of reporting requirements. Various mechanisms were presented e.g. MOUs, contracting arrangements, etc) for reducing these problems. **Recommendations** from the working groups included the need to assess SR capacity prior to contracting. Selection criteria should be developed by PRs and CCMs (without adding more bureaucratic levels or hindering transparency). CCMs should actively perform governance and oversight roles while PRs need to develop and manage contractual obligations, management, SR oversight. Better harmonization of programs at the community level is needed, including proactively streamlining and standardizing reporting systems and reducing paperwork and bureaucracy. Mechanisms such as designating lead sub-recipients to become responsible for managing sub-SRs (e.g. NGOs, private sector, faith-based organizations) were proposed as solutions.

Day 2: Tuesday, 28 March

13. The plenary session started with a review of the key recommendations from day 1. The second day of the meeting had two components: in session 3. partners (both offering technical and financial assistance) presented information on the types of support available to countries and how to access it. The plenary was briefed by the Chairperson of the Harmonization Task Force concerning task force support to countries. A brief case study on strategic planning was also presented by Nigeria. The second session of the day brought countries and partners together into country-specific groups to discuss implementation bottlenecks and develop strategies for addressing the bottlenecks.

Session 3 Partners Forum

14. In the first part of the day, each partner presented information on the types of assistance available for countries with malaria programmes and described the process for accessing it. The Harmonization Task Force Chairperson presented information on the types of assistance the task force was prepared to offer countries. Nigeria presented a case study on strategic planning.

15. Several **RBM partners** are committing significant resources to malaria control programs. Specific partners are targeting selected countries (PMI/USAID, WB Booster, PATH-MACEPA, etc.). PMI is targeting 15 countries by 2010 and has budgeted US$1.2 billion for this programme. Three countries have already received funding (Angola, Tanzania and Uganda). WB Booster is targeting 17 countries (Angola, Benin, Burkina Faso, DRC, Eritrea, Ethiopia, Ghana, Kenya, Malawi, Mali, Nigeria, Rwanda, Senegal, Sudan, Tanzania, Uganda, Zambia). Booster has set aside US$500 million to spend in these countries and will run for 10 years in the first intensive phase of the project. Countries may apply for loans by sending letters from the government (Ministry of Health and/or Finance and/or President) directly to the World Bank (a detailed proposal is not

necessary to start the process). The GFATM discussed the potential round 6, which if launched, would be after the GFATM Board meeting at the end of April 2006. If round 6 is launched, proposals would be due by August 2006. Donors are looking to provide funding through existing country plans. It was emphasized that countries should prepare proposals to fulfill their needs and cover any gaps in relation to scaling up programs which in turn should not be tailored towards the amount of money available.

16. Many of technical assistance partners from a wide variety of different RBM partners are already active in West and Central African countries, including: WHO, USAID, MSH, MSH RPM+, MACEPA-PATH, Malaria Consortium, Millennium Quick Impact Project, Constellation, PSI, JHPIEGO, AED/Netmark, MSH.

17. **Dr James Banda** (RBM Partnership Secretariat), the Chairman of **Harmonization Task Force** briefed the plenary on the Harmonization Task Force meeting highlighting that the RBM movement is diverse and a variety of technical and other types of assistance is available to countries. Harmonization is necessary at both the global and country levels. The RBM Partnership Global Strategic Plan (GSP) 2005 - 2010 has been produced with the input of many RBM partners. RBM partners have agreed to the goals and targets laid out in the GSP. During 2006-2010 countries need to achieve the Abuja declaration targets (countries that have not yet met the 2005 targets will need to catch up); by 2008 need 80% coverage of the different interventions. Planning for scale up to achieve 80% coverage is thus essential. The task force goal is to work with countries having problems with their GFATM malaria grants (10 grants in this region are in danger of failing) to resolve these issues and successfully implement their programmes.

18. Dr Olayemi Sofala, Programme Manager **Nigeria** presented information on the recently completed Nigerian planning process. Their experience indicates that planning framework is most effective when it is developed around a five year strategic plan; a three year operational plan; and a one year action plan. Nigeria planning includes two phases, phase one for catch-up to reach 80% coverage targets for vulnerable groups; phase two to consolidate gains and extend coverage to the general population. Strategy is built around prevention and treatment interventions. However, strategy and policy need to change as new evidence and resources become available (especially for vector control and the use of RDTs and home-based management of fevers). The strategy should include a component on communication and behavior change, health system strengthening to support implementation and M&E strengthening.

Session 4 Development of Country Action Plan for Scaling Up for Impact

19. In this session countries and partners worked together in country-specific groups discussing implementation bottlenecks and developing strategies to address these bottlenecks.

Day 3: Wednesday 29 March

20. Day 3 continued with in the finalisation of country action plans. Each country presented the action-plan developed in collaboration with RBM partners in Session 5 of the plenary. The meeting concluded in the plenary where key learning experiences of the workshop and next steps were agreed by countries and participants.

Session 5: Presentation of country action plans

21. **Benin** indicated that is facing problems related to: insufficient human resource capacity at the MoH and PR; problems with procurement of malaria commodities; initiating the new ACT policy; scaling-up implementation (esp. procurement, M&E and operational research); and fostering community involvement. The strategy to address these bottlenecks included: strengthening management capacities; developing a better performance and financial tracking system; improving contracting; looking for additional financial resources; developing a workplan for ACTs; better dissemination of technical materials and including a community response component in its round 6 application. Benin asked for assistance in developing its new five year strategic plan and developing its round 6 GFATM malaria proposal.

22. **CAR** is facing implementation problems including: insufficient human resources; weak capacity of local NGOs; late implementation of activities and delivery of malaria commodities. To address these problems CAR planned to train staff in technical areas (e.g. M&E), work more closely with NGOs to ensure their capacity; plan across programmes and to ensure timeliness; integrate cross-cutting programmes (e.g., ANC); accelerate deliveries of commodities; and strengthen the collection of routine information.

23. **DRC** identified the following implementation bottlenecks: insufficient national coverage for both preventive and curative interventions; insufficient and/or late procurement of malaria commodities (ACTs, LLINs); weak monitoring and evaluation system; insufficient quality assurance and drug monitoring; poor coordination of country RBM partners (including the NMCP and PRs); and a lack of national policy concerning tariffs on ACTs and ITNs. DRC will address these bottlenecks by accelerating the selection of SRs; rapidly allocate resources to purchase commodities; improve supervision of District and community-level activities; plan for timely ordering of commodities; ensure the rapid distribution of products; work to establish the three ones at country level; conduct training in M&E; disseminate information more widely; encourage staff at all levels to monitor and evaluate activities and impacts; establish a pharmacovigilance strategy; harmonize partner activities; provide subsidies for ACTs and LLINs and target vulnerable groups.

24. **Ghana** focussed on ensuring quality and adequate quantity of ACT drugs; phasing out monotherapies; and the need for an updated five year strategic plan. Ghana will address these issues by developing/reviewing systems for QA during procurement; developing/reviewing a plan for post-marketing product quality surveillance; procuring ACTs through WHO; facilitating the process of pre-qualification for local manufacturers; developing a timeline and process for phasing out monotherapies; increase the purchase and use of RDTs; improve data collection and monitoring; and hold a series of meetings to revise the five year strategic plan. Ghana indicated that they would welcome support from RBM partners to finalize their 5 year strategic plan.

25. **Guinea** identified weak procurement capacity; weak management capacity of the PR; weak capacity of the sub-recipients; weak monitoring and evaluation capacity; and poor motivation of PR staff. Guinea will address these bottlenecks by recruiting staff to work on procurement and supply chain management; identify other suppliers for mosquito nets; identify appropriate SRs to assist with distribution of commodities; recruit staff to improve financial and other management capacity; develop a list of suitable SRs; purchase software to help manage data and information. Guinea's plan was not well developed for the first two years, there were problems with capacity and implementation, they need to strengthen the program capacity and need help from RBM partners to strengthen the program and improve implementation. The targets in the plan have been adjusted, there is still some time to improve performance.

26. **Guinea Bissau** underlined the following implementation bottlenecks: weak capacity in the health system; poor distribution of ACTs; ITN distribution during vaccination campaigns; poor coordination of training; and an inadequate procurement and supply management plan. Guinea Bissau will address these bottlenecks by working with technical partners to strengthen capacities; develop a detailed workplan to forecast and procure sufficient quantities of ACTs in a timely manner; work with partners to improve ITN distribution during vaccination campaigns; and develop more coordinated staff training. Guinea Bissau needs more support from partners.

27. **Liberia** listed the following issues: inadequate ITN coverage, distribution and assessment of coverage; transportation difficulties; and forecasting to improve procurement. Liberia developed an action plan to resolve the bottlenecks that includes developing round 6 proposal to get more resources; improve the distribution and storage of mosquito nets; improve the reporting of health centres; use a database to improve forecasting and M&E. Liberia is looking for more financial resources and technical assistance, as currently, it does not have much of either. They need assistance to develop a round 6 proposal.

28. **Nigeria** identified the following implementation bottlenecks: policy on taxes and tariffs on imported malaria commodities; LLIN supply - technology transfer; poor performance of procurement agent; and budget shortfall to cover entire country. Nigeria developed an action plan to resolve the bottlenecks by: creating a national subcommittee to look at the issue of taxes and tariffs and try to exempt malaria commodities; exploring technology transfer to produce nets locally; work with current procurement agent to improve performance; explore other procurement alternatives (including direct procurement by partners); and explore additional opportunities for funding. Nigeria would like a consultant to prepare a case study of procurement bottlenecks and best practices, the case study could include several countries -Nigeria, Guinea and Ghana.

29. **Senegal** among others listed the following implementation bottlenecks: monitoring commodity use at the central and district levels; balancing supply and demand of commodities; distribution of technical instructions to the health workers at all levels; forecasting and adjusting stock levels; budgeting for different activities; and the procurement of ITNS. Senegal developed an action plan to resolve the bottlenecks by: tracking commodity consumption at the national, district and local levels; inputting all data into a database; training health care workers; identifying appropriate technical partners to provide assistance; request budgeting flexibility from donors; re-direct financial resources to best address problems; and consult with UNICEF to resolve problems with the procurement of ITNs. Senegal has been waiting for ITNs to be delivered. The problem with the nets was presented as a backlog with the supplier.

30. **Sierra Leone** identified the following implementation bottlenecks; procurement of ITNs, ACTs ;finalization of PSM plan; delay of case management and IPT training; inadequate storage facilities for ITNs and ACTs; inadequate human resource capacity at all levels; weak national health management information system; and sentinel surveillance planned but no budget. Sierra Leone developed an action plan to resolve the following bottlenecks by: completing the procurement and distribution plan; providing clarification on the PSM to LFA/GF; strengthening HR capacity at all levels; fast tracking the training process - TOT; government provided temporary storage; construction of WB funded storage facility to be fast tracked; training of staff in programme management, M&E etc; strengthening of HMIS by WB support is ongoing; developing a harmonized set of indicators; strengthening District and Hospital based data collection and reporting; locating external/government support for programme. Sierra Leone needs technical assistance and is looking for the involvement of more partners.

31. **Togo** identified the following implementation bottlenecks; coordination of activities by the CCM; delay in deliveries of malaria commodities; evaluation by the LFA to OK phase 2 of

round 3 grant ; communication plan for the distribution of ACTs; staff capacities in financial management and project planning; evaluation of 2001-2005 Strategic plan; and development of 2006-2010 strategic plan. Togo developed an action plan to resolve the following bottlenecks by: increasing awareness of the roles and responsibilities of the CCM; accelerating delivery solutions and looking for alternative systems; working with the LFA to ensure they can approve round 3 disbursement; organizing a workshop to develop a communication strategy; organizing training in project management software; organize the evaluation of the previous strategic plan and initiate a series of workshops to develop a new five year strategic plan. Togo would like partners to assist with the evaluation of the previous 5 year strategic plan and the development of the new 5 year strategic plan.

Session 6: Workshop Review and Emerging Issues

32. In conclusion, a number of factors that affecting GF disbursements were identified and dealt with by countries and partners in the country specific action-plans. Decision to disburse is based on performance: for that countries need to take action to solve their problems and not just wait for the problems to solve themselves. Countries will need to innovate to win the battle against malaria. NGOs can help in RBM but often they lack the capacity to implement programs. Capacity of local NGOs as SRs needs to be assessed and strengthen. Often there is a need for a more rigorous process for selecting NGOs with adequate capacity to implement programs. Partner experiences with the NGOs might provide a starting point for PRs. Contractual arrangements with NGOs should demonstrate that they have the capacity to implement programs before they are cas SRs.

33. So far, GF and USAID have sponsored several workshops on procurement; the challenge now remains to integrate the programmatic and operational processes. Countries need to anticipate problems by working to create demand in the community. USAID expressed willingness to continue working together with countries and partners. However, countries need to present TA needs upfront in proposals. Participants recommended that same type of initiative could be used in other regions. It was agreed that developing the plan is not an end in itself, plans need to be implemented. RBM partnership will help to identify partners who can help countries with implementation gaps.

34. TGF (West and Central Africa Cluster and OPCS) in collaboration with MSH/RPM+ and RBM will document in the form of case study experiences in implementing malaria grants in three selected countries: Ghana, Nigeria, Guinea Bissau.

35. West and Central Africa Cluster will track and document the methodology of the regional workshop and develop a “Workshop in a kit” that could be used by other teams in TGF Operations. OPCS in TGF will further consolidate the partners information matrix where contribution and involvement of each partner is identified and could be used by countries.

36. Whenever TGF, PMI and Booster Program work on the same country, the organizations agreed to strengthen planning and implementation of one planning monitoring and evaluation framework; to systematically share information and ensure joint planning and use of Malaria Indicators Surveys (MIS) and Malaria Indicator Cluster Surveys (MICS) for outcome and impact assessment; undertake joint appraisal of TA needs and support development and financing of malaria national strategy plans

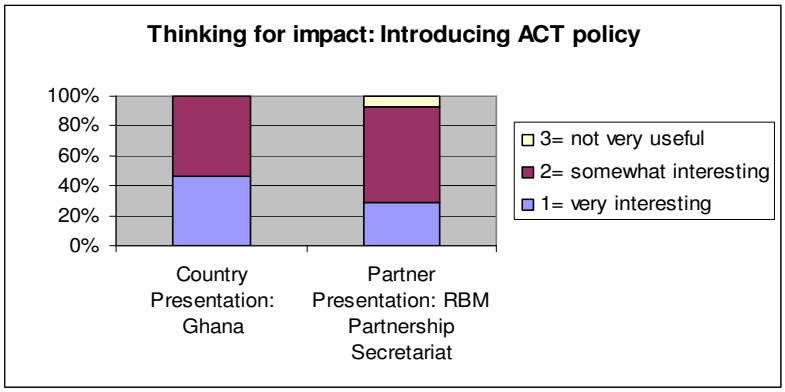
Meeting Closure

37. Dr James Banda, **RBM Partnership Secretariat** thanked TGF for allowing the RBM Partnership Secretariat to expand the scope of the meeting and include RBM partners. Stakeholders need to be engaged and participate in the process. The role of the RBM Partnership Secretariat is to ensure that the partnership works well and that results are achieved. RBM will follow up and track progress to ensure that targets specified at this meeting are met. For countries and RBM partners there is always a direct line of communication with the Partnership, HQ (James Banda), WARN (Claude Rwagacondo), and CARN (Célestin Ngabonziza).

38. On behalf of **GFATM** Mr Mabingue Ngom thanked all participants at the meeting, especially USAID and MSH for providing financial support to the meeting. saying that these meetings provide an opportunity for sharing of information but this is only the first step. Now there is a need to take it further to see action and results. Participants need to address problems, share the responsibility for resolving them and making progress. Countries were able to learn from each other during this process. Leadership is key in the fight against malaria. Technical assistance from partners is available and countries need to work with them to prepare solid proposals that take into account the resolution of bottlenecks.

Workshop Evaluation

39. Evaluation forms were distributed. Unfortunately only 14 completed forms were returned on which the following analysis is based.


Thinking for impact: Introducing ACT policy
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Country Presentation: Ghana
Partner Presentation: RBM Partnership Secretariat
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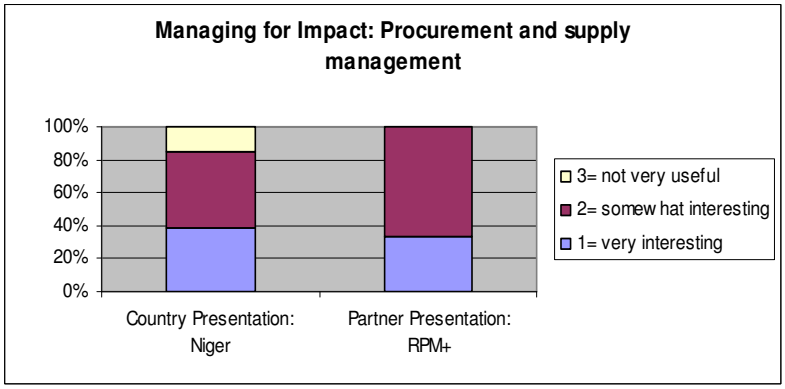
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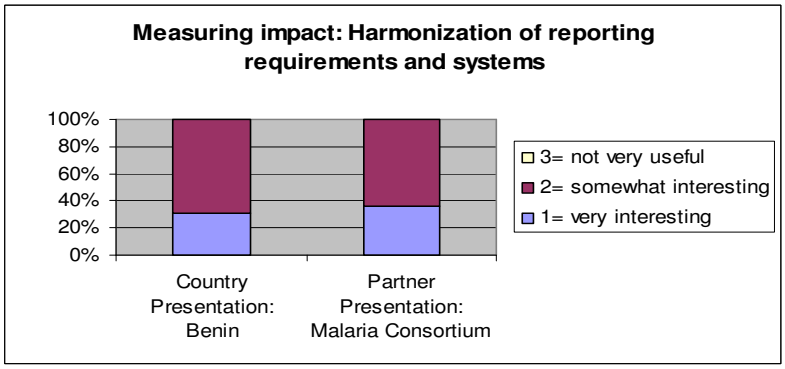
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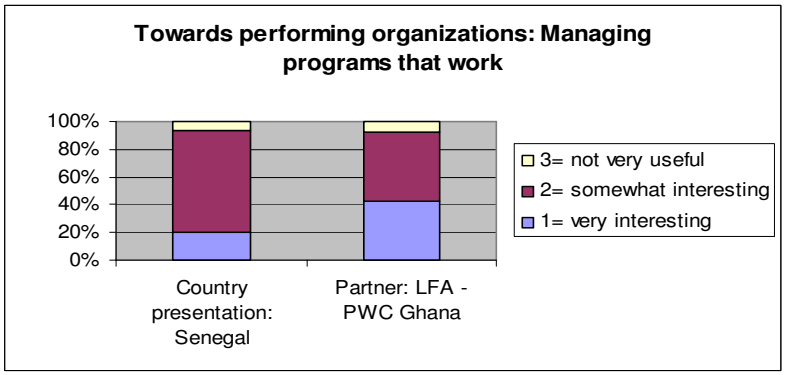
Towards performing organizations: Managing programs that work
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Country presentation: Senegal
Partner: LFA - PWC Ghana
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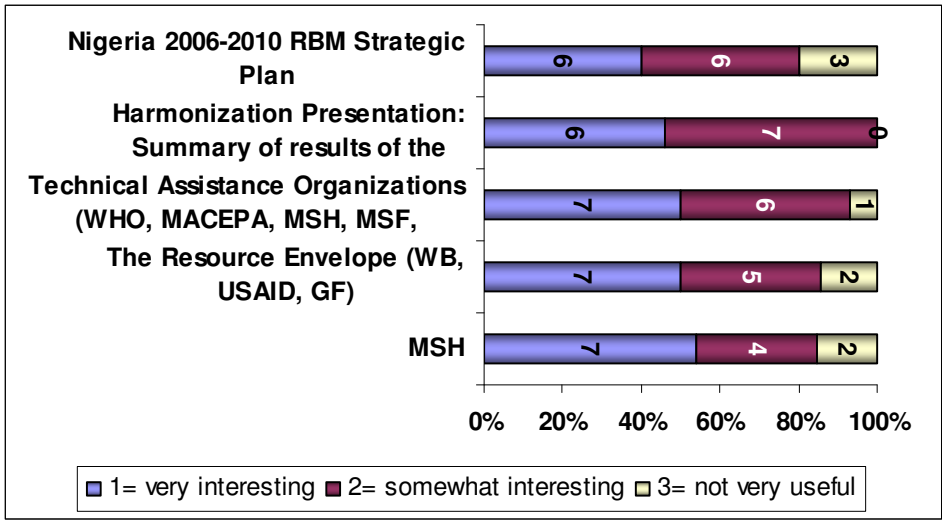
Nigeria 2006-2010 RBM Strategic Plan
Harmonization Presentation: Summary of results of the
Technical Assistance Organizations (WHO, MACEPA, MSH, MSF,
The Resource Envelope (WB, USAID, GF)
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